

THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

**SOAH DOCKET NO. 453-05-4328.M5**

MDR Tracking Number: M5-04-2833-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 05/04/04.

The IRO reviewed office visits, therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, and manual therapeutic technique for dates of service 05/14/03 through 06/30/03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

The office visits, therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, and manual therapeutic technique for dates of service 05/14/03 through 06/30/03 **were** found to be medically necessary. The office visits, therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, and manual therapeutic technique provided from 07/01/03 through 08/11/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, and manual therapeutic technique.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On 07/31/04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 99213 for date of service 06/09/03 denied as "D". Per Rule 133.307(e)(2)(A) the requestor has submitted a HCFA-1500 for the disputed date of service which supports that this CPT code was billed only once. Therefore reimbursement in the amount of \$48.00 is recommended.
- CPT Code 97265 for date of service 06/11/03. Neither party submitted an EOB. Per Rule 137.307(e)(2)(B) the requestor has submitted convincing evidence of the carrier receipt of the provider request for an EOB. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(C)(3) reimbursement in the amount of \$43.00 is recommended.

This Decision is hereby issued this 28th day of January, 2005.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf

## ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 05/14/03 through 06/30/03 as outlined above in this dispute.

This Order is hereby issued this \_28th\_\_\_\_ day of \_January\_\_\_ 2005.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/mf  
Enclosure: IRO Decision

## NOTICE OF INDEPENDENT REVIEW DECISION

July 22, 2004

**Amended Letter: 10/07/04**

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-2833-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care

professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This is a 64 year-old woman who was injured on \_\_\_\_ when she lost her balance while standing on a step stool. There was no fall, but she complained of pain to her lower back and neck. She continues to have severe chronic cervical and lumbar pain despite disc decompression surgery done 11/13/02 and multiple series of epidural steroid injections. Her diagnosis is lumbar discogenic pain, bilateral lumbar facet syndrome, cervical discogenic pain, bilateral cervical facet syndrome, and myofascial pain syndrome. Her treatment consists of extensive rehab of the cervical and lumbar spine with Chiropractic manipulation, full spinal manipulation, and magnetic therapy. She also is prescribed Soma, Lortab, Neurontin, and a topical gel consisting of Naproxen, Camphor, and Menthol.

### Requested Service(s)

Office visits, therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, and manual therapeutic technique for dates of service from 05/14/03 through 08/11/03 and therapeutic procedures, office visit, myofascial release, joint mobilization and neuromuscular reeducation on 06/19/03. Exclude review of office visit on 06/09/03, and joint mobilization on 06/11/03.

### Decision

Based on the review of the provided records (and excluding review of the office visit on 06/09/03 and joint mobilization on 06/11/03) the office visits, therapeutic exercises, myofascial release, joint mobilization, neuromuscular reeducation, and manual therapeutic technique for dates of service from 05/14/03 through 06/30/03 and therapeutic procedures, office visit, myofascial release, joint mobilization and neuromuscular reeducation on 06/19/03 were medically necessary to treat this patient's condition. However, any services provided from 07/01/03 through 08/11/03 were not medically necessary.

### Rationale/Basis for Decision

The records indicated the patient was injured on the job on \_\_\_\_\_. She received extensive treatment over the course of her injury. Her problems continued and she had disc decompression surgery on 11/13/02. She began an aggressive post-operative rehabilitation program on February 17, 2003. The surgeon continued to write a prescription for rehab each time he saw the patient.

National treatment guidelines allow for 2 to 4 months of post-operative rehabilitation for this type of injury. There is sufficient documentation in the records to allow for treatment. Additional rehabilitation was needed beyond what was provided prior to the denial of services beginning on 05/14/03.

On 06/30/03 the follow-up note from the surgeon indicated his desire to request the report of evaluation from Dr. Baker's office so he could provide the patient with further therapeutic options. He said he would like for the patient to undergo rehabilitation and chiropractic manipulation and joint mobilization if indicated. He would also like to obtain a series of three transforaminal lumbar epidural steroid injections at the levels of bilateral lumbar 5 and sacral 1 since the patient has exacerbation of pain after

percutaneous disc decompression and he would like to continue her current medications. The documentation indicates her condition had minimally improved and she had reached a point where there was minimal progress being made as a result of the rehabilitation and chiropractic program.

Given this fact, additional rehabilitation and chiropractic services beyond 06/30/03 were not clinically justified or medically necessary. In conclusion, it was usual, customary, reasonable and medically necessary for this patient to receive the provided services from 05/14/03 through 06/30/03. The services from 07/01/03 through 08/11/03 were not medically necessary for the treatment of her on-the-job injury.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment  
GBS:vn  
Attachment